Integration of Medicare and Medicaid in California: Provider Perspectives of Cal MediConnect

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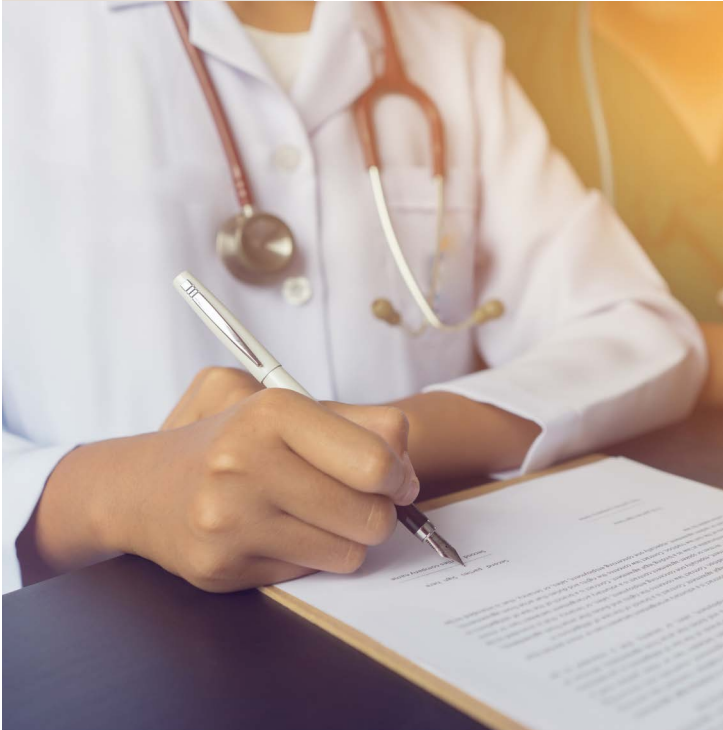
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EXECUTIVE SUMMARY

In 2014, California became one of 13 states to implement a financial and administrative alignment demonstration called the Coordinated Care Initiative (CCI).[1] In California, existing Medicare and Medi-Cal (California's Medicaid program) managed care health plans in seven counties created new products called "Cal MediConnect" (CMC).[2] In demonstration counties, beneficiaries eligible for both Medicare and Medi-Cal, sometimes called "duals," were passively enrolled into CMC plans, with an option to opt out. Those who were enrolled received all Medicare and Medi-Cal benefits, including both medical services and managed long-term services and supports (LTSS) through a single capitated CMC health plan. CMC plans were also required to provide care coordination services and coordinate behavioral health care.[3,4] By September 2017, more than 116,000 dual beneficiaries were enrolled in CMC plans.[5] To deliver these services, CMC plans developed corresponding provider networks, including primary care providers (PCPs), provider groups, federally qualified health centers (FQHCs), hospitals, and long-term care (LTC) providers.

Researchers from University of California conducted an evaluation of the impact of the CMC program on beneficiaries and health systems.[6] Data collected for this research brief built on Phase I results and included 19 additional interviews with provider stakeholders including physician providers, provider groups, CMC plan directors of provider networks, FQHCs, hospitals, management services organizations (MSOs), and LTC providers.

KEY FINDINGS

1. **Providers perceived CMC to be part of a general trend toward more integrated systems of care.** Providers acknowledged that CMC is just one example of the larger trend toward policies that integrated care through administrative and financial alignment. Providers generally wished to see the program sustained and improved.

2. **CMC's additional benefits added value, though awareness of them could be improved, and access more consistent.** Providers especially valued CMC's care coordination, transportation, durable medical equipment, vision, and pharmacy benefits. They also noted that awareness among beneficiaries and even front-line staff remains limited, and health plans' assistance was inconsistent. Providers generally encouraged further outreach and education.

3. **For some providers, CMC introduced more complexity into their client population, presenting challenges with time and resource management.** FQHCs were often unaccustomed to serving dually eligible beneficiaries and reported that they were unprepared for the complexity of medical care required for many of their new CMC members. This ultimately strained their internal resources, increased the workload for existing providers, and led to delays in care for all of their patients.

4. **Many providers experienced challenges navigating member eligibility data, as well as CMC referral and authorization processes.** Providers reported difficulty in accessing accurate information about member eligibility and enrollment in the Department of Health Care Services (DHCS) Automated Enrollment Verification System, and provider networks, leading to increased workloads and delayed referrals. Additionally, providers reported complex authorization processes that strained their internal resources and sometimes led to denied claims and disruptions in services.

5. **Providers struggled with care transitions without assistance from CMC plans.** Hospital providers reported challenges in care transitions when they were not able to work with the CMC plan to secure a placement at a LTC facility or identify primary care physicians or specialists available to provide follow-up care. Although *a 2016 dual plan letter (DPL) from DHCS* clarified the responsibility of the CMC plan to assist with transitions of care and identify LTC placements or follow-up specialists when needed, some providers still reported a lack of support from plans.

6. **Data collection and reporting processes created challenges for some providers.** Smaller provider practices without the organizational capacity to absorb an increase in workload were especially impacted by data collection and reporting requirements. Providers working with multiple plans and delegated provider groups reported the most difficulty in complying with multiple data collection and reporting workflows.

7. **Low CMC plan reimbursement rates led some providers to decline participation.** Providers reported that CMC's rates were too low to provide the care needed for some CMC members. Additionally, providers noted that they had few opportunities to negotiate rates with CMC plans. Providers' leverage to negotiate rates varied by region and demand for their services. However, some providers noted that lower rates could be tolerated if they are paired with increased referrals and assistance with care transitions.

8. **Provider contracting arrangements with CMC plans varied, sometimes including risk-sharing agreements.** Contracts with provider groups depended on the CMC plans' and provider groups' capacity to accept risk. While smaller groups were likely to maintain fee-for-service arrangements with CMC plans, larger groups that could exhibit capacity in the scope and depth of their services were better prepared to negotiate varying levels of risk sharing.

9. **Some barriers remained in aligning financial incentives between and across CMC plans and providers.** Providers especially noted the disincentive to transition people into the community when such a transition results in a lower risk categorization and a lower rate. Providers reported that this, along with high costs of maintaining someone's services in the community, posed a disincentive.

10. **CMC has facilitated data sharing, though progress varies among plans and providers.** For instance, providers reported that some CMC plans' data systems were better than others and that some plans had still not committed to a two-way data sharing process. Providers noted the importance of sharing data to improve provider collaboration and care coordination for CMC members.

RECOMMENDATIONS

1. **DHCS should continue education efforts about CMC benefits and requirements between providers and beneficiaries.**

2. **DHCS should work with counties to establish guidance on how to better maintain member eligibility and enrollment data in the DHCS Automated Enrollment Verification System.**

3. **DHCS should encourage CMC plans to establish more advanced and streamlined authorization processes.**

4. **Provider associations should disseminate the DHCS DPL 16-003 to their members, and CMC plans should review the DPL to ensure their current practice is in accordance with DHCS guidance.**

5. **DHCS and CMC plans should continue to partner with providers to streamline data collection and reporting processes.**

6. **The Centers for Medicare & Medicaid Services (CMS) and DHCS should continue to encourage the development of effective and interoperable data-sharing systems.**

7. **DHCS and CMC plans should continue to solicit provider feedback to improve CMC procedures and processes.**

8. **DHCS should explore legislative and financial opportunities to establish a clear provider complaint resolution channel to facilitate resolution of future challenges and track ongoing systemic problems.**

INTRODUCTION

In 2014, California became one of 13 states to implement a financial and administrative alignment demonstration called the Coordinated Care Initiative (CCI).[1] In California, existing Medicare and Medi-Cal (California's Medicaid program) managed care health plans in seven counties created new products called "Cal MediConnect" (CMC).[2] In demonstration counties, beneficiaries eligible for both Medicare and Medi-Cal, sometimes called "duals," were passively enrolled into CMC plans, with an option to opt out. Those who were enrolled received all Medicare and Medi-Cal benefits, including both medical services and managed long-term services and supports (LTSS) through a single capitated CMC health plan. CMC plans were also required to provide care coordination services and coordinate behavioral health care.[3,4] By September 2017, more than 116,000 dual beneficiaries were enrolled in CMC plans.[5] To deliver these services, CMC plans developed corresponding provider networks, including primary care providers (PCPs), provider groups, federally qualified health centers (FQHCs), hospitals, and long-term care (LTC) providers.

Researchers from University of California conducted an evaluation of the impact of the CMC program on beneficiaries and health systems.[6] Data collected for this research brief built on Phase I results and included 19 additional interviews with provider stakeholders including physician providers, provider groups, CMC plan directors of provider networks, FQHCs, hospitals, management services organizations (MSOs), and LTC providers.

BACKGROUND

Results from **Phase I** of this of this evaluation[i] revealed that the CMC demonstration impacted providers in several ways, and there were regional differences in provider competition and markets across CMC counties. For example, in northern California fewer independent providers resulted in a market dominated by a few large health systems and health plans, including provider groups and hospitals. Some respondents contended that this limitation led to decreased competition. In contrast, southern California counties had many more plans, hospitals, provider groups, and independent PCPs that were not linked to larger systems, which could increase competition and create more challenges for collaboration and communication between providers and multiple plans. Other regional differences were noted in access to LTC facilities, with more challenges related to capacity in northern California. The regional differences in provider experiences with CMC were also accentuated by the lack of statewide standardization of how the various plans contracted and worked with the providers to ensure adequate provider networks, effective care coordination, and access to services and supports. Some other results from the Phase I report that were built upon in this second phase included issues around access and benefits, administrative burden, financial impact and rates, and promising practices.

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[i] This research brief builds on results from Phase I of this evaluation which was released in July 2016. That report examined the early impacts that CMC had on various health system stakeholders, including providers, and their experiences within the first 18 months of CMC program implementation. However, as Phase I focused primarily on interviews with CMC health plans, input from physicians, hospitals, and other providers that serve CMC beneficiaries was limited. Where relevant, **key findings** from Phase I are referenced here in our Phase II findings.

Several types of providers were interviewed for this current research brief, including:

Primary Care Providers (PCPs): PCPs include physicians and other health care providers, such as nurse practitioners.

Provider Groups: Provider groups are sometimes called independent practice associations (IPAs) or participating provider groups (PPGs). IPAs and PPGs are associations of independent physicians, or other organizations that contract with independent physicians, and provide services to managed care organizations on a negotiated per capita rate, flat retainer fee, or negotiated fee-for-service (FFS) basis. Depending on the delegation arrangement, either the plan or the provider group will accept responsibility for payment of downstream provider claims. These groups can also include hospitals. Plans may delegate out certain medical and care coordination requirements to provider groups.

Federally Qualified Health Centers (FQHCs): FQHCs provide care for millions of low-income Californians, many of whom are uninsured or have Medi-Cal. FQHCs can be either public or private, non-profit and serve as a "safety net" for many of its clients. To qualify as an FQHC, the following four conditions must be met: (1) Serve in a medically-underserved community; (2) Provide preventive care, primary care, and supportive services; (3) Provide services on a sliding fee scale, with fees adjusted based on the person's ability to pay; and (4) Be governed by a majority of community members who represent the clients being served. The number of FQHCs varied by CMC county, ranging from a low of seven in San Mateo to a high of 208 in Los Angeles as of 2016.[7]

Hospitals: Hospitals are a common site of care for dually eligible beneficiaries due to their high rates of chronic illness and complex care needs. They are also often an integral part of efforts to transition patients back into the community or into LTC or post-acute settings.

Long-Term Care (LTC) Providers: LTC providers included skilled nursing facilities (SNFs) and other similar post-acute, intermediate, or rehabilitative care facilities. CMC opt-out rates were high among dually eligible LTC residents, and LTC providers were required to contract with CMC health plans for their residents who did not opt out.

Management Services Organizations (MSOs): MSOs are independent entities that operate between plans and providers to deliver administrative support services.[8] With the expansion of managed care delivery systems, MSOs have grown in scope and scale. While some MSOs may solely focus on administrative support, others can employ advanced data analytics and tap into non-clinical resources to help coordinate care for especially complicated populations.

CMC Plan Directors of Provider Networks and Services: Directors of provider networks and services are often employed within health plans. They assist with developing adequate provider networks and establishing contractual relationships with providers to deliver required benefits to their members.

METHODOLOGY

With input from the project stakeholder advisory group, potential respondents were identified based on their experience with CMC, regional representation, and representation of targeted types of providers. A total of 19 interviews were conducted over the telephone between January 2017 and September 2017. Interviews lasted between 20-90 minutes.

Provider respondents included PCPs (n=1), provider groups (n=5), FQHCs (n=3), hospitals (n=4), LTC providers (n=3), MSOs (n=1), and plan provider representatives (n=2). Respondents can be loosely categorized into two groups of expertise: organizational executives and administrators such as executive directors, CEOs, presidents, and vice presidents (n=13); and frontline direct service providers such as PCPs, nurses, social workers, and case managers (n=6).

With input from the study's stakeholder advisory group, a provider interview guide was developed. Every interview was transcribed after which two members of the research team independently coded the transcript. The research team then met to review the coding and discuss areas where codes were in disagreement. The findings' key themes are summarized below.

FINDINGS

Findings from provider interviews included the following general themes: (1) CMC integration, benefits, and access; (2) CMC administrative challenges; (3) CMC financial impacts on providers; (4) communication and data sharing; and (5) the future of CMC.

Implementing Integrated Care through Cal MediConnect
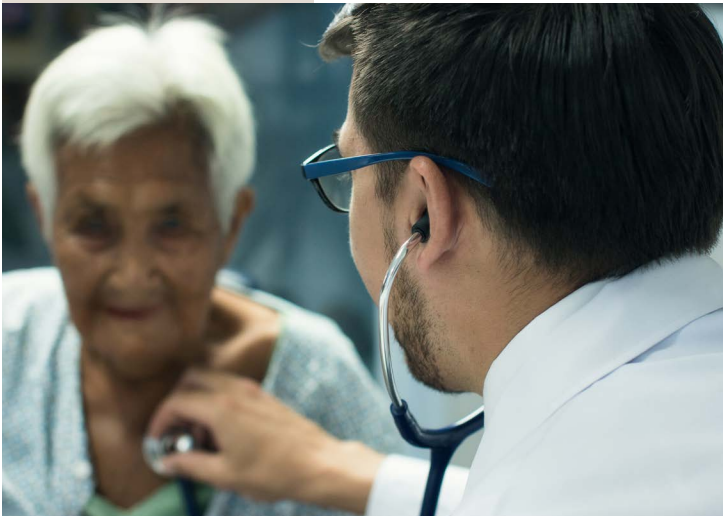
A number of providers indicated that CMC has become better integrated between the providers and the CMC plans and easier to navigate for the CMC beneficiaries compared to when it first started in 2014.

Integrated Care is the Right Approach: Several providers interviewed noted that many of the challenges reported in _**earlier research**_ had been resolved, with systems of care normalizing three years post-CMC implementation. One respondent from a provider group reported that although such a complex program was likely to face some challenges during implementation, the program itself should lead to a better, integrated benefit structure for patients in the long term.

"The challenge with CMC… [is] that it is a very complex administered program. So, it has been a challenge to really maneuver and navigate the extra benefits and the vendors that are subcontracted through the health plan, along with all the other types of products that we have with these other health plans. I think it's been a challenge really to have a seamless implementation of what on paper is a better benefit structure and a better consolidated, comprehensive resources for patients." – Provider Group

Longer Planning Periods Could Improve Implementation: One LTC provider recommended a longer lead time for planning and development of integrated systems like CMC in order to fully build the relationships and communication channels needed among the California Department of Health Care Services (DHCS), the CMC plans, and the providers, as well as the core infrastructure needed for the CMC implementation. Another provider noted that this lead time was especially important when implementing a program for a population challenged by multiple medical and behavioral conditions.

> *"I think one of the things that I hope people learn from this is, if you're going to ever do something like this again, you need to have an 18-month to two-year ramp-up period, in which people can communicate, develop relationships, develop systems, and feel comfortable, that when someone pulls the trigger to go, the people are ready, and that's just not the case of what we saw in this program."* – LTC Provider

Integrated CMC Benefits Add Value to Care

The CMC program integrates a variety of benefits for dually eligible members, and providers were asked to comment on whether these integrated services were impacting the care they provided to their patients. Though most providers said that the care they provided was not significantly impacted by the payer, many mentioned the CMC care coordination, transportation, durable medical equipment (DME), vision, and pharmacy benefits as adding value to the care they were able to provide. However, some providers mentioned some CMC members were not aware of CMC's additional benefits and more education is needed to improve awareness and access.

CMC Care Coordination: A key method for integrating care was the new care coordination benefit provided by CMC plans and their delegated provider groups. CMC care coordinators were responsible for coordinating both medical services and LTSS. In our past ***research brief*** we noted that CMC care coordinators often facilitated access to Medi-Cal services such as Community-Based Adult Services (CBAS) and In-Home Supportive Services (IHSS). Additionally, CMC plan care coordinators often facilitated ***more seamless care transitions*** and possibly reduced the cycle of hospital and SNF readmission. Many providers confirmed the importance of CMC care coordinators in facilitating care transitions.

> *"Whether it's hospital to SNF, hospital to home, SNF to home, SNF back to hospital, SNF to long-term care, those transitions are the absolute key, and those are usually where the gaps arise and the hand-offs… are incomplete. I think it's really enabled some really good conversation, again, about the who does what, and it has surfaced issues that we have in this community about just simply the lack of long-term care beds."* – CMC Plan

One FQHC noted that CMC facilitated coordination and continuity of care through "anchoring" the patient to the FQHC as the patient's medical home. This helped the FQHCs to manage patients who previously had multiple providers who were not communicating with each other.

> *"I think they have become more stable. And what I mean by that is before, patients who had Medi-Medi tended to go all over the place… But, I think this program has provided some stability in the sense that you know that your patient is going someplace because you referred them. And therefore, I think the coordination of care is much better through CMC as opposed to when it was just Medi-Medi."* – FQHC

Several providers, however, reported some limitations to care coordination provided by the CMC plans. Providers noted that some CMC plans were better than others at providing consistent care coordination services. Hospital providers, especially, noted challenges accessing plans' care coordinators to assist with member discharges.

> *"The key issue was not having access to the care coordination services that we all believed going into this were going to be the hallmark of this program. We heard time and time again from [hospital] case managers that… if a patient needed to go to another level of care, or needed a particular procedure, or needed a physician, they were basically given a list [from the plan] and told, 'okay – go for it and let us know when you have done it.'"* – Hospital Provider

Some providers reported that for CMC to succeed, there needs to be more dedicated support and financial resources for care transitions and care coordination.

> *"I think that the intent was good, but I think if they really want to coordinate care, I think they're going to have to be willing to spend more money and have care coordinators, and have people that are responsible for this."* – LTC Provider

Nearly all providers expressed a desire for a clear determination of who should take the lead in coordinating care. One hospital provider suggested a more comprehensive leadership role by the state to provide direct guidance and education about the policy requirements and modes of CMC implementation to the CMC plans, hospitals, community health centers, LTC facilities, and physician provider groups. This would help to ensure all are in agreement about how to deliver and coordinate care to CMC beneficiaries. Without such a determination, members may not receive the care coordination they need, or providers may be duplicating care coordination efforts.

Transportation: When asked about what CMC benefits were particularly valuable, providers usually mentioned transportation. Most plans typically offered approximately 30 rides per year. Providers noted that this service allowed patients to more easily attend appointments.

> *"They have 11 transportation services each way, so they can come to their appointments, through transportation services. We have a lot of patients that are in gurneys or wheelchairs, so they'll go to the house, pick them up and then bring them back to the hospital. Typically, they'll wait here rather than leaving them and then picking them up, so the patients aren't waiting for a period of time. Yeah, the transportation services are great."* – Provider Group

However, another provider reported that beneficiaries were often not aware of transportation benefits, which could lead to inconsistent access and utilization of the benefit.

> *"Most of the patients are not aware, and so then we help to inform them, but then they need to [call] their [CMC] health plan to set up the transportation in advance of their specialist appointment… But I don't know that a lot of our patients have accessed that as well as maybe they could."* – FQHC

Durable Medical Equipment: Some providers reported that CMC improved access to DME for some members, and they often had an easier time getting DME for CMC members.

"I have noticed that our patients with straight Medicare have a more difficult time securing specialists and repairs to DME equipment… The difference is when we do their incontinence supplies, the different supplies, the patients are guaranteed to get their supplies. Whereas with straight Medicare, it's very difficult to obtain supplies or wheelchair repairs, any type of DME repairs. The DME aspects are great with the Cal MediConnect patients." – Provider Group

Another hospital respondent reported that they're seeing patients getting supplies more quickly through CMC plans, which has facilitated timely care transitions.

"On the provider level, they definitely recognized that the patients at Cal MediConnect were definitely getting what they needed in a much more timely manner than was happening before. And I think that relates to a lot of authorization for certain services and getting the DME that they need… so that they can stay out of a skilled nursing facility or come out of the hospital quickly." – Hospital Provider

One FQHC also reported that a positive consequence of CMC's development of the clinic as the patient's medical home was that direct-to-consumer marketing fraud for DME has reduced.

"I can tell you in the past, there were some fraudulent people… that would target these types of patients for durable medical equipment, for things like power wheelchairs and back braces… People would market to those patients directly and they would give them their Medicare information. The patients that are now CMC… they're with a plan. If you need a power wheelchair, you have to come to your medical home to be processed for that. So, I think in terms of fraud in health care… I'm sure that it has made a difference." – FQHC

Vision Services: Some providers mentioned that CMC's vision benefit was helpful to some new dual eligible members who did not have vision care before. This benefit made a major difference to them as they could now get their eyes checked and obtain a new pair of glasses.

"The vision has been great. I have a patient that needed a new pair of glasses for years and was able to obtain a new pair of glasses. When she was with Medicare, she's wheelchair bound and wasn't able to transfer from wheelchair to the exam chair. And we were having a hard time trying to find an ophthalmologist to see her. However, when she converted to Cal MediConnect, she was able to go to another ophthalmologist, and she was able to be seen in her chair when she couldn't transfer. That was great." – Provider Group

Pharmacy Services: Some providers expressed that pharmacy services improved and became more efficient when a CMC plan worked closely with the physicians to develop a set formulary. This new formulary fit well with the medication needs of the CMC members.

> *"In terms of pharmacy, I think having the [CMC] health plan, their pharmacy benefits are probably a little bit more robust. You don't get as many callbacks from the pharmacy and as many denials from the pharmacy because now you know for sure you're dealing with the formulary. And whatever the [CMC] health plan formularies are, they allow those pharmacy benefits."* – FQHC

However, when a needed medication was not within the set formulary of a CMC plan, one provider reported that it had created additional paperwork and time for the providers to seek and receive authorization for the medications, leading to delays in getting the medication to the member.

CMC Impacted Provider Administrative Resources

Providers reported administrative challenges they faced included increasing patient complexity, data collection and reporting, referrals and provider directories, and authorization requirements.

Providers Challenged by Complexity of CMC Member Needs: Many providers reported that CMC members had more complex care needs than their average clients. Some FQHCs reported being especially challenged by the increased number of duals they served, which increased their workload. One FQHC reported that they made more referrals after CMC implementation due to the increased acuity and multiple conditions of CMC members. Another FQHC claimed that because of the increased acuity of their CMC members and longer visits, they had to increase wait times for all of their patients.

> *"Typically, our visits are 15 minutes long. When you have a CMC patient, that tends to be a 30-minute visit… It has impacted our scheduling… in the sense that our regular patients… we have to schedule them further out in order to accommodate everyone, because we do not have the luxury of just hiring new human resources to manage the increase… [Now], our regular chronic stable patients, we have them come back in four months, instead of three."* – FQHC

One PCP reported that the complexity of CMC members and requirements pushed some smaller providers to opt out of participating in CMC.

> *"I think some bowed out because, ultimately, they couldn't afford to see that population base, and those that stayed in have accepted the level of complexity that comes with that population."* – Primary Care Provider

Data Collection and Reporting: *Past research* suggested that new CMC regulatory changes and additional data collection and reporting requirements, such as Health Risk Assessments (HRAs), led to strained financial and administrative capacity for some providers. Some providers interviewed for this study noted that CMC data collection and reporting requirements were necessary to monitor quality and assess CMC impact, and that these assessments could potentially provide added value to monitoring and identifying CMC member needs.

"I mean, sometimes as health care providers, we get caught up in the chronic illness aspect of the patient and forget some of the other social and other aspects of the patient… With [CMC], it does force you to make room for that assessment. And I think in the long run the patient benefits, because there are things that you can identify when you dig into the social aspects of the patient, that you may not have even realized is impacting the patient. Just yesterday I had an elderly lady who I was seeing, and her blood pressure was elevated and I'm thinking, well maybe you need more medication. And she's like, 'No, the person I'm staying with is about to be evicted and then that means that I have no place to go.' So, it's those types of … it's that forcing you as a provider to look at not just the illness, but social factors that may be impacting the illness." – FQHC

However, another provider noted that although assessments can be helpful, they don't always make sense for members who don't require such intensive care planning. They suggested that providers be given leniency to target their care coordination efforts to those populations with the highest need.

Several providers noted that completing assessments (e.g., HRAs, Annual Wellness Exams), though not unique to CMC, were especially challenging as each CMC plan required forms and processes that were different from, and in addition to, the provider organization's own internal electronic health record (EHR) reporting needs.

"They require that we do an annual wellness exam on these patients. And that, if I can be frank, is quite burdensome. The form that is supplied to us to complete an annual wellness exam is about 10-12 pages long. And not only that, [Plan A] has their own, [Plan B] has their own, [Plan C] doesn't really have one, but they approach it a little bit differently in the sense that they just require us to provide the gaps in care, or validation of certain preventative services. [Plan D] has their own. So… you're having to deal with four different health plans with four different annual wellness exam forms. Essentially, they're asking the same questions. But it would be nice if they can get together and provide one annual wellness exam form, which can then be converted into an electronic version." – FQHC

One plan respondent reported a concern that through policies like CMC, reporting requirements can become ends in and of themselves rather than serving the purpose they were originally intended to serve.

"The requirements of HRAs and care plans, there's nothing wrong with the policy, but in practice if too much time and effort is spent on simply trying to do them rather than how do you kind of holistically look at the population and how to best manage the population… I think what ends up happening is that the compliance requirements, because they're there and because they're measured and because they're reported, sometimes I think end up overshadowing the reason that those things are in place in the first place and sometimes they become ends in and of themselves." – CMC Plan

This respondent recommended that CMC requirements be reviewed to ensure that they are working as intended and that they are helping providers deliver the best services possible. Another provider group suggested that requiring documentation, without actual communication, may not be enough to ensure real integration of care.

> "…It would be much more value added if there was a requirement that somebody… who has a mental health condition talk to the clinical team that does the case management in the IPA or group model. To actually force the conversation to emulate more of a real integrated delivery system as opposed to requiring the documents to be the driving model of integration." – Provider Group

CMC Impacted Provider Referral Protocols: Some providers reported that CMC facilitated members' referrals to PCPs and specialists within their provider network.

> "[CMC has] way, way better coordination. And also, I would even say, ease of access to specialty providers, because once they are within the health plan [network], then we know that you have contracted specialists, as opposed to when they are Medi-Medi, you have to search around… Once the patient is Cal MediConnect, they're in a plan. You have your contracted list, and you just go with that. It makes that process a whole lot easier. So, I would say, it has eased the burden in terms of access to specialty care for sure." – FQHC

Other providers reported increasing complexity of making referrals for CMC beneficiaries due to the complex contracting arrangements with CMC plans and a lack of current information about contracted entities. Additionally, providers reported that inadequate provider and patient data systems led to challenges identifying contracted providers and determining where to send claims.

> "The eligibility data that's managed by DHCS doesn't connect individual providers in the networks who would be eligible to provide services to dual beneficiaries… I've heard complaints from community-level specialists who've said that they've tried to access a file… but it's a flat file type of database that doesn't recognize a provider's multiple affiliations… It makes it very difficult for providers that are not contracted into a particular IPA network. These doctors have had a tough time getting the right information on where to submit their bills." – Provider Group

While challenges with provider directories aren't unique to CMC, they were especially problematic for providers in CMC regions with numerous plans and networks of providers.

> "We work with more than 10 plans and each of those plans has three or four different products with different structures. There are literally 40 plus workflows based on benefit structure and vendors, differing between each of those… Many times [this] leads to some confusion and poor patient experience because there's some confusion on who is the right vendor for this plan versus that plan… The plans many times don't really have a clear understanding of, and don't really communicate out, who are their plan partners as routinely as probably could be done." – Provider Group

Some providers noted that problems with provider directories were less present in counties with county-organized health systems due to the presence of a single plan for CMC beneficiaries as well as long-standing provider networks.

One provider group mentioned that a Provider Directory Collaborative has been convened and is in the process of developing a new provider directory. This new provider directory could include PCP, provider groups, hospitals, LTC facilities, and even community-based organizations that are registered as providers.

CMC's Authorization Requirements Impact Provider Resources and Member Access:

Providers noted that it often took more time and more paperwork to get pre-authorization of services for CMC beneficiaries. Several providers noted that they spent a significant amount of time attempting to determine a plan's network of post-acute providers and getting authorizations or waivers in order to discharge CMC patients. As one LTC provider noted,

> *"Regular Medi-Cal residents, the authorization that we get for them is for two years. Every two years we would need to get a new one, but with the [CMC] health plans it's only for six months. The workload for us increased four times. Instead of doing it every two years, we're doing it every six months."*
> – LTC Provider

One PCP reported that member eligibility and plan and delegated provider group affiliation were not adequately updated by the county in the DHCS Automated Eligibility Verification System (AEVS) which led to additional complications in billing and out-of-network claims.

> *"I've had appeals from practices where the AEVS information said that this patient is with a managed Medi-Cal plan… It turns out that they sub-delegated to another plan. The doctor wasn't contracted with that plan. When they appealed, they were told that the claim wouldn't be paid because they didn't get authorization for this plan they didn't know they had to participate with… It ultimately went to the department [DHCS] and said, 'Department, this is your eligibility information that is inaccurate. I've tried to work with both plans. Will you help me?' Ultimately, we didn't see any assistance on that matter."* – Primary Care Provider

A hospital provider reported that the process of discharging a patient to post-hospital levels of care was particularly difficult due to authorization requirements and narrower LTC provider networks.

> *"I think where it has become the biggest change… is that if a patient is in a hospital and needs a post-hospital level of medical care, prior to CMC, if a patient was traditional Medicare they could pretty much assess the patient clinically, work with the physician and transition them into a post-hospital level of care, whether it be rehab, LTAC [long-term acute care], or skilled nursing. Now those post hospital services have to be in-network, and [you] have to get some level of authorization. So, it adds a layer of complexity which was there before for certain payers, but it significantly ramps that up."* – Hospital Provider

Some providers reported impacts on access to services, supports, and care transitions as a result of complicated authorization processes. For example, some hospital providers noted incidents where CMC members were kept in the hospital for extended periods due to challenges with identifying appropriate placements in the community or a LTC facility.

> "…we have seen a marked increase over the past couple of years of individuals remaining in the hospital for extended periods of time because they can't find an appropriate post-hospital placement or they are waiting for authorizations. That's obviously problematic from a cost standpoint usually falling to the hospital because they don't usually get any reimbursement for that extra time. But more importantly is a compromised clinical outcome; patients don't do as well if they stay in the hospital longer than they need to. So, I would say that hospitals are unfortunately becoming boarding facilities for some of these patients that they can't transition to the community. Again, that is not specific to CCI and CMC but I think it's a part of it." – Hospital Provider

Hospital providers reported that one common challenge was with CMC plans that would stop payments if a hospital was having difficulty discharging a patient to a LTC facility.

> "It is kind of annoying to [hear], 'By the way, we stopped paying on the 10th because the patient was appropriate for a lower level of care.' [Especially when] those five days [were] either A, trying to get an authorization from you or B, trying to find a facility that will take your patient." – Hospital Provider

In 2016, DHCS issued **DPL 16-003** to clarify the responsibility of CMC plans in discharge planning and care transitions, including the identification of post-discharge specialists and securing and authorizing of LTSS or placement in a LTC facility. However, one provider raised concerns that lack of assistance with care transitions and denials for authorization of services may be more prevalent than they were aware of because many frontline providers and staff didn't have the knowledge to better advocate for their patients.

> "If a plan tells a [hospital] case manager, 'no, we don't do that', or 'you are the one who has to do it', they may not know enough to say… 'well wait a minute, that is not how this program is supposed to work.'… I am concerned there are additional folks remaining in the hospital beyond the time they need to, or not getting paid for, or not getting the care coordination, but it is not bubbling up because nobody there really knows any better." – Hospital Provider

Whether the challenge is due to a lack of CMC plan adherence to the guideline or to provider's lack of awareness, these barriers to appropriate and timely care transitions could negatively impact beneficiaries.

One FQHC noted some progress through the development and adoption of more automated authorization processes by one plan, which has reduced the burden on the provider.

> *"The CMC patients recently moved to a more automatic referral authorization so for most of the specialties, once we put in the referral, it generates an automatic authorization number so it doesn't have to get reviewed by the health plan. So that helps to reduce the time needed to get the prior authorization."* – FQHC

It is not certain how many CMC plans have begun implementing more automated authorization processes, but such an approach could be considered a best practice.

CMC Had Financial Impacts on Providers

Previous research found that some providers, especially independent PCPs, preferred to serve regular Medicare patients rather than accepting lower Medi-Cal rates, leading to low participation in CMC. Provider groups were able to pool administrative resources, often enabling them to adapt to managed care environments more easily than their independent practice counterparts.

When asked about the financial impact of CMC, providers often noted challenges, particularly their dissatisfaction with rates, denied claims, risk sharing, and financial disincentives. Providers reported that these challenges were often unresolved, but that with time they learned how to better operate within CMC to prevent future challenges.

Rates: The most common complaint issued by providers was that CMC rates were too low and continued to drop over time, leading some providers to decline participation.

> *"I think it was a reaction by the established provider groups that the rates were so much lower than Medicare Advantage that they didn't feel they could break even on the population providing the level of services [needed], and so they declined to participate."* – Provider Group

A CMC plan respondent reported that a hospital provider refused to contract with them due to CMC's low rates, which unfortunately narrowed their network of hospital providers.

> *"When you have a hospital that wants significantly higher rates than these programs are funded at, you just can't do it."* – CMC Plan

A few providers discussed efforts to negotiate rates with CMC plans, with most reporting a lack of leverage or outright dismissal.

> *"They don't negotiate, they just tell you what they're going to do… and you say, 'Well, wait a minute, I can't make it on X%.' They say, 'Fine, don't contract with us, we'll give those patients to other people.' There's your negotiation: you take our price, or you don't take our patients."* – LTC Provider

Some providers reported that their leverage to negotiate depended largely on the availability of provider services in the regions where the plans were operating. For example, in southern California where there was greater LTC capacity, those facilities had less leverage to negotiate higher rates. Similarly, in areas where large provider groups were prevalent, the ability of smaller provider groups or independent PCPs had less ability to negotiate.

Some providers suggested that CMC plans could mitigate the impact of low rates through higher referrals and better transitions to ensure that services are delivered at the appropriate level of care.

> *"So [Plan X] may only pay me 85 cents on the dollar, but they give me 50 patients a day, where you may be 100% on the dollar and you give me two patients a day. Who do I like better?"* – LTC Provider

> *"It's engaging providers in not just the payment conversation but, again, where do we best provide these services? For example, with a hospital, it's less about rate negotiation than it is about making sure that the people [who] are at the hospital really need to be at the hospital."* – CMC Plan

One provider group noted that they had created a VIP program for their members with certain hospitals that they preferred their members to use. The hospital was told that through this VIP program, their members would be incentivized to utilize their services, but that the hospital was expected to provide higher quality care and services for those VIP members.

> *"We don't limit the hospital network, but we do incentivize the members to utilize particular hospitals through this VIP program."* – Provider Group

Denied Claims and Delayed Payment: With California's somewhat complicated delegation arrangements between plans and providers, some providers reported that they had difficulty keeping track of who they should bill once services were provided.

> *"Let me give you an example… So [let's say hypothetically that] it's January of 2014, and I'm an LA County provider, I own two [facilities] and I bill two groups, I bill the Medi-Cal program weekly and I bill the Medicare program weekly. We now bring in Cal MediConnect, and I have seven managed care organizations, and those seven managed care organizations have 22 IPAs. I now have 29 separate organizations I potentially have to bill, collect, and deal with. How do you think the independent owner can survive without hiring one or two full-time staff just to do the billing and the collection and all that?"* – LTC Provider

Additionally, this LTC provider also noted that some IPAs had not complied with requirements to adopt electronic billing practices, requiring instead that other providers submit paper bills and wait for checks to be mailed to them.

Billing challenges also arose as a result of members switching from one plan to another, which sometimes led to delayed billing. As one LTC provider reported, once the claims were sent to the correct plan, they were over the 180-day limit and the claims were deemed "untimely."

> *"One of the issues that we had at the beginning was some of our residents being placed in one plan one month, and then switched to another plan the following month. We, as a provider, ended up losing some of our claims because we would send them to one place and then to the other, and neither one took responsibility for the claim. We ended up having to write off some of the claims from 2014… going back and forth billing it, so it ended up being untimely billing."* – LTC Provider

The 180-day limit in CMC is more restrictive than that in Medicare, which rejects claims as untimely after a full year, and allows decreased payments for anything sent after six months. Relaxed designation of claims as untimely during program implementation would allow for necessary provider adjustments to new claims and billing procedures.

Providers reported that associations were often asked to step in to help negotiate some of these issues with the CMC plans and DHCS. One provider reported outstanding claims dating back to the beginning of the demonstration in 2014, more than three years ago.

This challenge was likely exacerbated in regions where LTC facility beds are scarce or plan LTC networks are limited. Another hospital provider described how delayed payments to LTC facilities further impacted their ability to transition patients out of the hospital.

> *"There were some issues where a SNF was identified as being in network but then when they were called… we were having a problem with them saying well… 'yeah, we're contracted but they haven't paid us in three months, so we're not accepting anybody else until we get caught up.' Some of that might be growing pains."*
> – Hospital Provider

Contracting and Shared Risk: As reported in ***earlier research***, CMC has resulted in complicated and fluid contracting arrangements between CMC plans and providers. One provider group reported that these delegated arrangements enabled plans to offload the risk of their most complex members to provider groups. Some provider even noted that policies like CMC increased the prevalence of capitated provider groups.

> *"Yeah, the plans really… even public plans turn to capitated provider groups to handle the duals population. Where they had directly contracted networks before, they've offloaded a ton of risk onto the capitated provider groups to service these populations, where the groups have been willing to accept it. Not all groups have."* – Provider Group

Contracts with provider groups varied depending on plan and provider group capacity to accept risk, with smaller and less experienced provider groups often maintaining FFS arrangements with CMC plans. However, larger provider groups with experience serving duals populations were often sought out by plans to serve their CMC members through a per member per month arrangement. This shouldered the group with risk as well as potential rewards if members' care was managed well.

One provider group reported that some CMC plans are building their internal capacity to provide care management, and subsequently reducing rates to provider groups who were previously paid to provide care management.

"Some health plans are basically taking money and building internal care management infrastructure and then continuing to decrease rates for the capitated groups and that's been an issue of concern." – Provider Group

A CMC plan noted that whether they were delegating or not, their role needed to be that of the convener, bringing everyone together.

"Rather than us as a health plan building everything or us delegating and saying, 'You build it,' our role I think is increasingly that of being the link and the convener and the information gatherer and disseminator." – CMC Plan

Whatever the delegation model, providers recommended that capitated payments be based on risk-adjusted methods, where delegated entities receive higher payments for higher-risk members. This approach would both protect delegated groups covering exceptionally "high-risk" populations as well as discourage provider groups from accepting only healthier members.

Financial Incentives Not Yet Fully Aligned: One plan respondent noted that financial incentives were still not fully aligned through CMC as some disincentives remain to support people's care in the community.

"[If] you do all the right things and keep people independent, then there isn't really funding. You move them down the category from 'institutional' to 'home and community high' and then they're in 'community well' [category] and you get less money. We get less money, but we move them down so we are saving the system money, but who's paying for them to stay in their home because they don't have the income to do it? I think it's way too simplistic to say if you coordinate care then the federal government's going to save money, the state government's going to save money and the plan or delegating to the MSO, everything's going to be just great." – CMC Plan

Some FQHCs noted that the CMC financing model is disconnected from the existing FQHC and provider group financing and care delivery models. They argued that financing and care delivery models need to be integrated, and should be more of a patient-centered model rather than an administrative or financing-centered model.

Regarding the alignment of financial incentives among various providers, one hospital provider noted that diagnosis-related groups ensure that the incentives between the plans and the hospitals are aligned, ensuring appropriate admissions, admission times, and services. However, another hospital provider reported that incentives to transition members out of the hospital efficiently were misaligned between the plan and the hospital.

"There is a real desire to hold dollars tight. It very often feels like keeping the dollars under control is more important than serving the patient. On the hospital side, that's painful. I'm taking care of your schizophrenic, 400-pound patient, and you're telling me that you're done paying me because I don't have a SNF for him at your rate. I'm not sure where it broke down. I think because hospitals are held responsible, both through value-based purchasing and through the readmission penalty program, I think that the plans know that the hospitals are on the hook for readmissions and that we're going to try everything we can to prevent them, so I don't think they feel on the hook for that at all." – Hospital Provider

In contrast, a LTC provider noted that they had collaborated with one CMC plan to avoid unnecessary hospital readmissions for urinary tract infections (UTIs) by being granted a higher rate.

> *"If they do have a UTI, we've had instances where we've just called the plan, and we explained the situation, and they do give us authorization for a higher rate payment for seven days or whatever their need is, instead of sending the resident to the hospital."* – LTC Provider

However, this respondent clarified that this was not happening with any of the other plans they worked with.

Data Sharing and Communication are Crucial to the Integration of Care

In *earlier research* we found that CMC's integration led to various models of care including fully-, partially-, and non-delegated models, which necessitated new partnerships and increased data sharing and communication among plans, providers, and various health system stakeholders. Respondents for this study confirmed the importance of data sharing to facilitate integration and coordination of care. Some providers reported that data sharing between the plan and providers as well as across provider types has improved under CMC.

> *"There's a lot of data sharing happening, which I think probably [is facilitated] in Cal MediConnect with having a single plan. It's like having the whole picture of what's happening in a person's life so that you can address the true underlying cause of what's ailing them and why they're showing up at the health care provider."* – Provider Group

However, many providers noted a need for better-integrated data systems that could share information both ways. For example, hospital providers mentioned that plans often demanded more patient information (e.g., HRAs, Annual Wellness Exams) from the hospital than they were willing to share with them.

> *"I haven't seen as much improvement in this area as I would like. For us, the level of communication tends to be very health plan specific. There seems to sometimes be more demands for information from us than [they are] willing to share information with us."* – Hospital Provider

Providers also mentioned needing a more integrated data sharing system with various sources of data.

Data Systems and Capacity Varied Across Plan and Providers: Although not specific to CMC, data system variability posed a challenge for providers working with multiple CMC plans. For example, one LTC provider described working with multiple incompatible EHR systems.

> *"I'm a nursing facility, and I'm dealing with seven different managed care organizations; I guarantee that's seven different electronic records systems… The compatibility of these electronic health records systems is very, very difficult."* – LTC Provider

Data sharing across providers was also a challenge, with one provider group said that their data sharing with IHSS programs was still done over the phone.

With variable plan and provider data systems and capacity, CMC may struggle to overcome basic challenges to data-sharing and communication during the short demonstration timeframe. Health system reforms that rely upon improved communication must also ensure that data-sharing systems are established and capable of facilitating enhanced communication.

Lack of Data Sharing and Poor Communication Could Negatively Impact Care: One hospital provider said the lack of hospital-to-hospital data sharing negatively affected transition of care for patients across hospitals. Another FQHC described how the lack of data sharing between providers presented a particular challenge when treating patients with low health literacy, who came in with no knowledge of what tests or treatments were completed at other sites.

> *"The patient might have a diagnosis of breast cancer. Okay, when is the last time you went to the oncologist? They don't know. Who were you seeing? They don't know. Were you on maintenance medication? What medicine? … When you have that person in front of you, now you're expected to continue to care for this person, but you don't know where you are in the process."* – FQHC

In these scenarios, FQHC case managers would attempt to track down the patient's records from whatever sources they could find. If unsuccessful, the FQHC has to restart tests and treatments, resulting in waste and duplication of time and effort.

CMC has Encouraged the Development of Best Practices in Data Sharing and Communication: Providers reported that some CMC plans' use of EHRs and advanced data systems facilitated communication and care coordination.

> *"We have provided [Plan A] and [Plan B] with access to [all] our electronic medical records. They can see everything too. That has really helped with authorizations and patient care."* – Hospital Provider

Providers applauded one plan's efforts to improve data sharing through payment incentives.

> *"One of the things I learned about [Plan X] was their process of tying some reimbursements to the providers submitting data and sharing data with the plan. [The plan tells us,] 'We want you to connect into the Health Information Exchange and we're going to put a significant portion of your quality bonuses online… That's just a smart way of doing it. [They are] trying to break down the walls of people not sharing their data."* – MSO

Despite the widespread recognition that data sharing and communication are crucial to CMC's success, barriers still exist due in part to diversity in systems of care. This diversity implies that no single solution to the challenge exists, but rather that time is needed for solutions to be developed in each unique instance.

Providers Challenged by Lack of Clear Complaint Resolution Pathway: Providers recommended developing better provider complaint resolution pathways to help them address challenges with programs like CMC. One LTC provider recommended that plans should meet regularly with provider associations to ensure that any challenges are addressed in a timely fashion. Another hospital provider reported that they held meetings to facilitate communication and resolve problems.

"[We hold a] joint operation meeting… Our team meets with their UR [utilization review] team, their physician. We do it quarterly, every three months. We all come together in a room and talk about what's working, what's not working so that we can have better relationships." – Hospital Provider

While CMC members had access to an ombudsman to resolve complaints, providers found it difficult to communicate with DHCS regarding challenges they were experiencing. One PCP noted that they were referred to a state contracted entity to address problems related to CMC, but often complaints were left unresolved. Another hospital provider recommended a complaint resolution channel be set up for providers.

"We feel there are a lot of these issues that aren't being meaningfully tracked by the department [DHCS]. So along with that education and providing that support to providers, I would also say just adequate and timely oversight by the department… We really believe that DHCS as the administrator of the program, they need to be the ones rolling up their sleeves and working on these issues with the plans [and providers]… We need a way for real-time problem resolution… I think [for] the problems that we have identified, [having] an ombudsman would be great if there's an individual problem to try to get fixed, but I also think… that there has to be some way to identify the systemic issues." – Hospital Provider

Developing a provider complaint resolution pathway would formalize the complaint process as well as allow for the identification and monitoring of more systemic problems that are best addressed through programmatic or policy solutions. However, as CMC is a contract among plans, the DHCS, and the Centers for Medicare & Medicaid Services (CMS), such a pathway will likely require additional legislation and dedicated funding.

Provider Perspectives on the Future of CMC: While many providers had challenging experiences with CMC, even the most critical of providers reported that, "the worst thing they [DHCS] could do is to stop [CMC]." Providers often noted the role of CMC as part of a larger trend of reforms toward more integrated systems of care, multi-disciplinary care teams, and focusing on social determinants of health.

"There's the general movement towards things like multidisciplinary care teams, using lower-level workforce… to help achieve your outcomes. Thinking about social determinant of health… All of these things are pretty consistent. I think there's lots of things we could draw parallels [to] the experience that's been happening so far in Whole Person Care and maybe Cal MediConnect." – Provider Group

Another provider group reported that they appreciated the framework provided by CMC, which allowed for full accountability and incentives.

"I don't like when let's say a [Medicare Advantage] plan can save money by putting cost to the Medicaid side… That's pointless… I think that by providing full accountability [through CMC], you're creating the right framework and incentives to improve. Now, that might take a while… I am hopeful [CMC will] continue because I think otherwise [there is] fee-for-service, which lets people play shell games that I don't think is good either." – Provider Group

Other providers reported being uncertain about CMC as a long-term solution. This was seen as especially true given changes in the political climate, efforts to repeal and replace the Affordable Care Act (ACA), potential rising health care costs, and the likelihood of imposing caps on Medicaid.

> *"Depending on where we go with ACA Repeal and Replace or any changes in policy coming out of CMS that would impose some type of a cap on California's Medicaid payments, I think the state should look very, very closely at greater managed care implementation across all counties for high-utilizer patients."* – Provider Group

In terms of future innovations, one provider suggested the need for a more integrated model for duals that ensures public and private sectors of the health care system are working in tandem and sharing the responsibility to serve CMC beneficiaries. Another suggestion was to encourage more future pilot programs and more CMS innovation. Several providers noted optimism about the **Health Homes Program**, **Whole Person Care Program**, and other waivers.

> *"The longer-term question will be, how do these various programs merge over time, or how do we build the lessons from them into the normal fabric of how we operate in each of these programs."* – Provider Group

KEY FINDINGS

1. **Providers perceived CMC to be part of a general trend toward more integrated systems of care.** Providers acknowledged that CMC is just one example of the larger trend toward policies that integrated care through administrative and financial alignment. Providers generally wished to see the program sustained and improved.

2. **CMC's additional benefits added value, though awareness of them could be improved, and access more consistent.** Providers especially valued CMC's care coordination, transportation, durable medical equipment, vision, and pharmacy benefits. They also noted that awareness among beneficiaries and even front-line staff remains limited, and health plans' assistance was inconsistent. Providers generally encouraged further outreach and education.

3. **For some providers, CMC introduced more complexity into their client population, presenting challenges with time and resource management.** FQHCs were often unaccustomed to serving dually eligible beneficiaries and reported that they were unprepared for the complexity of medical care required for many of their new CMC members. This ultimately strained their internal resources, increased the workload for existing providers, and led to delays in care for all of their patients.

4. **Many providers experienced challenges navigating member eligibility data, as well as CMC referral and authorization processes.** Providers reported difficulty in accessing accurate information about member eligibility and enrollment in the Department of Health Care Services (DHCS) Automated Enrollment Verification System, and provider networks, leading to increased workloads and delayed referrals. Additionally, providers reported complex authorization processes that strained their internal resources and sometimes led to denied claims and disruptions in services.

5. **Providers struggled with care transitions without assistance from CMC plans.** Hospital providers reported challenges in care transitions when they were not able to work with the CMC plan to secure a placement at a LTC facility or identify primary care physicians or specialists available to provide follow-up care. Although *a 2016 dual plan letter (DPL) from DHCS* clarified the responsibility of the CMC plan to assist with transitions of care and identify LTC placements or follow-up specialists when needed, some providers still reported a lack of support from plans.

6. **Data collection and reporting processes created challenges for some providers.** Smaller provider practices without the organizational capacity to absorb an increase in workload were especially impacted by data collection and reporting requirements. Providers working with multiple plans and delegated provider groups reported the most difficulty in complying with multiple data collection and reporting workflows.

7. **Low CMC plan reimbursement rates led some providers to decline participation.** Providers reported that CMC's rates were too low to provide the care needed for some CMC members. Additionally, providers noted that they had few opportunities to negotiate rates with CMC plans. Providers' leverage to negotiate rates varied by region and demand for their services. However, some providers noted that lower rates could be tolerated if they are paired with increased referrals and assistance with care transitions.

8. **Provider contracting arrangements with CMC plans varied, sometimes including risk-sharing agreements.** Contracts with provider groups depended on the CMC plans' and provider groups' capacity to accept risk. While smaller groups were likely to maintain fee-for-service arrangements with CMC plans, larger groups that could exhibit capacity in the scope and depth of their services were better prepared to negotiate varying levels of risk sharing.

9. **Some barriers remained in aligning financial incentives between and across CMC plans and providers.** Providers especially noted the disincentive to transition people into the community when such a transition results in a lower risk categorization and a lower rate. Providers reported that this, along with high costs of maintaining someone's services in the community, posed a disincentive.

10. **CMC has facilitated data sharing, though progress varies among plans and providers.** For instance, providers reported that some CMC plans' data systems were better than others and that some plans had still not committed to a two-way data sharing process. Providers noted the importance of sharing data to improve provider collaboration and care coordination for CMC members.

RECOMMENDATIONS

1. **DHCS should continue education efforts about CMC benefits and requirements between providers and beneficiaries.** To ensure broad access to CMC's benefits, education is needed for both beneficiaries and providers. Additionally, provider education about CMC requirements and regulations are still needed to improve adherence as well as member experiences.

2. **DHCS should work with counties to establish guidance on how to better maintain member eligibility and enrollment data in the DHCS Automated Enrollment Verification System.** To ensure that providers are able to navigate appropriate provider networks and bill CMC plans, counties must maintain accurate and informative member eligibility and enrollment data in DHCS's Automated Eligibility Verification System (AEVS).

3. **DHCS should encourage CMC plans to establish more advanced and streamlined authorization processes.** Efforts to digitize authorization processes could make the process more efficient for providers, prevent delays in care transitions, and avoid negative beneficiary experiences.

4. **Provider associations should disseminate the DHCS DPL 16-003 to their members, and CMC plans should review the DPL to ensure their current practice is in accordance with DHCS guidance.** DHCS should encourage CMC plans to develop Memorandums of Understanding with providers, especially hospitals, to clarify protocols for care coordination and transitions of care.

5. **DHCS and CMC plans should continue to partner with providers to streamline data collection and reporting processes.** DHCS and CMC plans should continue efforts to develop universal assessment tools with input from providers about how such assessments can better integrate with their own data collection needs and systems.

6. **CMS and DHCS should continue to encourage the development of effective and interoperable data-sharing systems.** As communication and data sharing are essential to successful care coordination, additional efforts are needed to improve and make consistent the data sharing capacities of CMC plans and providers.

7. **DHCS and CMC plans should continue to solicit provider feedback to improve CMC procedures and processes.** Promising practices, such as scheduling recurring meetings with CMC plans and network providers and soliciting feedback from provider associations, could help promote continued improvement of the CMC program.

8. **DHCS should explore legislative and financial opportunities to establish a clear provider complaint resolution channel to facilitate resolution of future challenges and track ongoing systemic problems.** To ensure that challenges faced by providers are addressed in a timely fashion, a protocol for providers to issue complaints is needed. Such a system should also be able to highlight systematic challenges faced by providers, which may require adjustments to program implementation and policy.

ACRONYM LIST

ACA: Affordable Care Act

AEVS: Automated Enrollment Verification System

CMC: Cal MediConnect

CMS: Centers for Medicare & Medicaid Service

CBAS: Community-Based Adult Services

CCI: Coordinated Care Initiative

DHCS: Department of Health Care Services

DPL: Dual Plan Letter

DME: Durable medical equipment

EHR: Electronic health record

FQHC: Federally Qualified Health Center

HRA: Health Risk Assessment

IHSS: In-Home Supportive Services

IPA: Independent practice association

LTC: Long-term care

LTSS: Long-term services and supports

MSO: Management services organization

PPG: Physician provider group

PCP: Primary care provider

SNF: Skilled nursing facility

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